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DATE: September 29, 2017

TO: Interested Parties

FROM: Stefanie Nadeau, Director, MaineCare Services

SUBJECT: **Emergency Adoption:** Chapter 101, MaineCare Benefits Manual, Chapter II, Section 29, Support Services for Adults with Intellectual Disabilities or Autism Spectrum Disorder

The Department is adopting this emergency rule to make the following changes to Chapter II, Section 29: (1) an increase in the combined services cap from \$23,985 to \$52,425; (2) the addition of Shared Living (Foster Care, Adult) as an available covered service to members; (3) the removal of Work Support services from and the addition of Shared Living services to the combined services cap; (4) an increase in the Respite Services cap from \$1,000 to \$1,100; and (5) the removal of the weekly cap for Home Support-Remote Support services.

These emergency rule changes were triggered by P.L. 2017, ch. 284, An Act Making Unified Appropriations and Allocations for the Expenditures of State Government, General Fund and Other Funds and Changing Certain Provisions of the Law Necessary to the Proper Operations of State Government for the Fiscal Years Ending June 30, 2018 and June 30, 2019 (“Act”). Part A, Sec. A-34 of the Act provides funding to increase the annual cap for combined services provided under the MaineCare Benefits Manual, Chapter II, Section 29.07-2, from \$23,771 to \$47,500. The Act authorizes the Department to adopt this change on an emergency basis without the necessity of demonstrating that immediate adoption is necessary to avoid a threat to public health, safety, or general welfare. See Part TTTT, Sec. TTTT-1.

The Department understands that the justification for increasing this cap to \$47,500 under the Act was to enable Section 29 members to have the option to apply for residential services under this waiver program. Therefore, this emergency rulemaking also adds Shared Living (Foster Care, Adult) services to the covered benefits under Section 29. To implement these services, the Department is adding definitions of Administrative Oversight Agency, Shared Living, and Shared Living Provider in Section 29.02 (Definitions), as well as provider requirements for Shared Living (Foster Care, Adult) in Section 29.10-4. These added definitions and provider requirements are consistent with Chapter II, Section 21, Home and Community Benefits for Adults with Intellectual Disabilities or Autism Spectrum Disorder, which also offers Shared Living services. The Department is also including Shared Living in Appendix IV, which describes additional requirements for providers related to organizational structure, personnel management, operational policies and procedures, financial management, and environment, consistent with other Section 29 providers. The Department is likewise engaging in concurrent emergency rulemaking to add Shared Living services rates to Chapter III, Section 29, so that eligible members can begin receiving these services. All of these changes are integral to fully implementing the new Shared Living service. These changes are immediately necessary for the safety and welfare of the vulnerable members of Section 29 who are in urgent need of the residential services the Department believes the Legislature contemplated in increasing the cap under the Act. 5 M.R.S. § 8054.

The Department also understands that the \$47,500 cap increase authorized under the Act not only accounted for the addition of Shared Living services, but also accounted for the removal of Work Support services. Removing Work Support services from the cap, and including Shared Living services within the cap, as described in Section 29.07-2 (Limits), will immediately benefit members who may be eligible for residential services. Additionally, this change positively impacts members by allowing members who receive Work Support services to engage in these services with

fewer restrictions. The Department asserts that these changes are necessary on an emergency basis in order to implement the Legislature's authorization to increase the cap. Absent these changes, members will be immediately and negatively impacted and restricted from receiving services the cap was intended to provide. 5 M.R.S. § 8054. The Department has also increased the annual cap from the \$47,500 in the legislation to \$52,425. The Act directed the Department to increase the Shared Living services rates under Chapter III, Section 21 for SFY2018 (effective July 1, 2017 through June 30, 2018). See Part MMMMMMM, Sec. MMMMMMM-2(1). The Department has calculated the annual cost of the newly added Shared Living service to Section 29, at the increased rate for this service in Section 21, and has determined that the cap should be set at \$52,425 (instead of \$47,500) to fully benefit Section 29 members who may now be eligible for this service. Without this increase on an emergency basis, members will be harmed by not having full access to services and providers will be negatively impacted by having a disparity in rates between these Sections. 5 M.R.S. § 8054.

The addition of Shared Living services to Chapter II and the reconfiguration of which services are included under the combined services cap at Section 29.07-2 will be effective October 1, 2017, as this is the first date Shared Living services will be available to members. However, the new cap of \$52,425 for combined services under Section 29.07-2 will be retroactive to July 1, 2017. The reason for having the cap retroactive is two-fold. First, the Legislature increased the cap in the Act (to \$47,500) based on fiscal year calculations – i.e., starting on July 1, 2017. Second, the Act directs the Department to increase rates of reimbursement for procedure codes in Chapter III (effective July 1, 2017 to June 30, 2018), which the Department is doing through a concurrent emergency major substantive rulemaking. See Part MMMMMMM, Sec. MMMMMMM-2(2). Increasing the cap retroactive to July 1, 2017, will allow for the increased reimbursement rates to providers without harming members. 22 M.R.S. § 42(8).

For similar reasons, the Department has increased the annual cap on Respite Services from \$1,000 to \$1,100 to accommodate the rate increase for this service for SFY2018 directed by the Act and for which the Department is engaged in concurrent Chapter III rulemaking. Absent this cap increase on an emergency basis, members will be immediately be harmed if providers are able to retroactively submit claims at higher rates and no adjustment is made to the Respite Services cap (i.e., members' access to these services will be decreased). 5 M.R.S. § 8054. For this reason, the Department is adopting this change retroactive to July 1, 2017, as permitted under 22 M.R.S. § 42(8).

The final change in this emergency rule is the removal of the weekly cap from Home Support-Remote Support services under Section 29.05-7. Home Support services (both Remote and ¼ Hour) are currently included and will continue to be included under the combined services cap in Section 29.07-2. Removing the weekly hourly cap will accommodate the increase in the annual cap to \$52,425 so as to avoid immediate harmful effects on members. 5 M.R.S. § 8054.

Overall, the Legislature's authorization of an increased combined service cap and the related and necessary changes described above will enable Section 29 members to have increased flexibility in receiving services with fewer restrictions. The Department is seeking and anticipates approval from the Centers for Medicare and Medicaid Services for these changes.

Pursuant to 5 M.R.S. § 8054(3), this emergency rule will be effective for 90 days. The Department will be pursuing routine technical rulemaking for Chapter II, Section 29 to avoid any lapse.

Rules and related rulemaking documents may be reviewed at and printed from MaineCare Services website at <http://www.maine.gov/dhhs/oms/rules/index.shtml> or, for a fee, interested parties may request a paper copy of rules by calling 207-624-4050. For those who are deaf or hard of hearing and have a TTY machine, the TTY number is 711.

If you have any questions regarding the policy, please contact Provider Services at 1-866-690-5585 or TTY users call Maine relay 711.

Notice of Emergency Agency Rule Adoption

AGENCY: Department of Health and Human Services, MaineCare Services

CHAPTER NUMBER AND TITLE: 10-144 C.M.R., Chapter 101, Chapter II, Section 29, Support Services for Adults with Intellectual Disabilities or Autism Spectrum Disorder

ADOPTED RULE NUMBER:

CONCISE SUMMARY: The Department adopts this emergency rule in accordance with P.L. 2017, ch. 284 (*An Act Making Unified Appropriations and Allocations for the Expenditures of State Government, General Fund and Other Funds and Changing Certain Provisions of the Law Necessary to the Proper Operations of State Government for the Fiscal Years Ending June 30, 2018 and June 30, 2019*), which provided funding to increase the annual cap for services provided under Section 29 from \$23,771 to \$47,500. The Act funded Shared Living services as a new residential Covered Service available to eligible members under Section 29.

The Department has increased the annual combined services cap from the \$47,500 in the legislation to \$52,425, to accommodate the annual cost of the newly added Shared Living service, given the rate increase for this service for SFY18, as implemented in a contemporaneous emergency rule for Chapter III, Section 29. In addition, the Department is adding Shared Living, and removing Work Support from, this cap, which will now include Home Support, Community Support, and Shared Living. The Department has increased the annual cap on Respite services to accommodate the rate increase for this service for SFY18 in Chapter III, Section 29, which the Department is also engaged in concurrent emergency rulemaking. Both of these increases in caps will be retroactive to July 1, 2017, pursuant to the increased rates for services in the legislation, and pursuant to 22 M.R.S. 42(8).

The emergency rule implements these changes by adding definitions for Administrative Oversight Agency, Shared Living, and Shared Living Provider, and by adding Shared Living as a Covered Service. The combined services cap has been increased to \$52,425, and Shared Living has been added to the services included under the cap. Work Support-Individual and Work Support-Group have been removed from the cap. Removing these services from the cap removes the limit on Work Support, and allows members flexibility to use the capped amount for the other services. The annual limit on Respite has been increased from \$1,000 to \$1,100. The weekly cap on Home Support-Remote Support has been removed to increase member flexibility.

These changes are not expected to have an adverse effect on the administrative burdens of small businesses.

<http://www.maine.gov/dhhs/oms/rules/index.shtml> for rules and related rulemaking documents.

EFFECTIVE DATE: October 1, 2017

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CHAPTER II

SECTION 29 SUPPORT SERVICES FOR ADULTS WITH INTELLECTUAL DISABILITIES OR
AUTISM SPECTRUM DISORDER ESTABLISHED 1/1/08
EMERGENCY RULE Last Updated: 10/1/17

The Department is seeking and anticipates receiving CMS approval for this Section. Pending approval, Covered Services will be provided as follows:

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The Department is seeking and anticipates receiving CMS approval for this Section. Pending approval, Covered Services will be provided as follows:

29.01 INTRODUCTION

The Home and Community Based Benefit (HCB or Benefit) for members with Intellectual Disabilities (ID) or Autism Spectrum Disorder (ASD) gives members eligible for this Benefit the option to live in their own home or in another home in the community thus avoiding or delaying institutional services. The Benefit is offered in a community-based setting as an alternative for members who qualify to live in an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID). The Benefit supplements, rather than replaces supportive, natural personal, family, work, and community relationships. It does not duplicate other MaineCare services.

The HCB Benefit is provided under a Federal 1915(c) waiver that meets Federal standards. MaineCare members may receive covered services as detailed in other sections of the *MaineCare Benefits Manual*, but can receive services under only one Home and Community Based waiver at any one time.

In addition, the planning process includes identifying and documenting the member's needs in a Personal Plan. The Personal Plan describes certain facilitative, therapeutic, and intervention services and supplies with an overall goal of community inclusion.

The Benefit is a limited one. Each year the Department of Health and Human Services (DHHS) must identify the total number of unduplicated members it will provide the benefit to during that year. If there is no funded opening, or if a member is not eligible for a funded opening based on priority, the member is placed on a waiting list as described in this rule.

29.02 DEFINITIONS

29.02-1 Abuse is defined in 22 MRSA §3472 and means the infliction of injury, unreasonable confinement, intimidation or cruel punishment that causes or is likely to cause physical harm or pain or mental anguish; sexual abuse or sexual exploitation; financial exploitation; or the intentional, knowing or reckless deprivation of essential needs. "Abuse" includes acts and omissions.

29.02-2 Activities of Daily Living (ADL) are:

- A. **Bed Mobility:** How person moves to and from lying position, turns side to side, and positions body while in bed;
- B. **Transfer:** How person moves between surfaces to/from: bed, wheelchair, standing position (excluding to/from bath/toilet);
- C. **Locomotion:** How person moves between locations, in room and other areas. If in wheelchair, self-sufficiency once in chair;
- D. **Eating:** How person eats and drinks (regardless of skill);

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29.02 DEFINITIONS (cont.)

- E. **Toilet Use:** How person uses the toilet room (or commode, bedpan, urinal), transfers on/off toilet, cleanses, changes pad, manages ostomy or catheter, adjusts clothes;
- F. **Bathing:** How person takes full-body bath/shower, sponge bath and transfers in/out of tub/shower (exclude washing of back and hair); and
- G. **Dressing:** How person puts on, fastens, and takes off all items of street clothing, including donning/removing prosthesis.

29.02-3 Administrative Oversight Agency:

- a. Is approved by DHHS's Office of Aging and Disability Services (OADS).
- b. Enters into a contractual agreement with the Shared Living Provider for oversight and monitoring services.
- c. Bills and receives MaineCare reimbursement; and
- d. See additional qualifications as described in in 29-10.4.

29.02-4 Autism Spectrum Disorder (ASD) means a diagnosis that falls within the category of Pervasive Developmental Disorders, as defined in the *Diagnostic and Statistical Manual of Mental Disorders* (American Psychiatric Association), that manifested during the developmental period, in accordance with the definition of autism codified in 34-B MRSA §6002 and accompanying rules.

29.02-5 Agency Home Support means a Provider Managed Service Location that routinely employs direct care staff to provide direct support services.

29.02-6 Authorized Entity is the organization authorized by the Department of Health and Human Services (DHHS) to perform specified functions pursuant to a signed contract or other approved signed agreement.

29.02-7 Case Manager is a person who works in determining, coordinating, and arranging appropriate and available services for members and facilitating the development of the Personal Plan. This person may also be referred to as an Individual Support Coordinator.

29.02-8 Clinical Review Team (CRT) is a multi-disciplinary team of qualified professionals that have work experience with adults with Intellectual Disabilities and Autism Spectrum Disorder. The CRT will partner with the resource coordinators to review and approve Medical Add-On; all initial classifications to the waiver; and home support service requests. The CRT will also be responsible for systematic reviews to

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The Department is seeking and anticipates receiving CMS approval for this Section. Pending approval, Covered Services will be provided as follows:

29.02 DEFINITIONS (cont.)

determine that members are authorized at an appropriate level of service in accordance with the member's personal plan.

29.02-9 Correspondent is a person designated by the Maine Developmental Services Oversight and Advisory Board to act as a next friend of a person with Intellectual Disabilities or Autism Spectrum Disorder.

29.02-10 Designated Representative means the DHHS staff or Authorized Entity authorized by DHHS to perform specified functions.

29.02-11 Direct Supports are a range of services that contribute to the health and well-being of the member and his or her ability to live in or be part of the community. Direct support services may include personal assistance or services that support personal development, or services that support personal well-being. The emphasis and purpose of the direct support provided may vary depending on the type of service.

Direct supports include the following:

Personal Assistance is assistance provided to a member in performing tasks the member would normally perform if the member did not have his or her disability. Personal assistance may include guiding, directing, or overseeing the performance of self-care and self-management of services.

Self-Care includes assistance with eating, bathing, dressing, mobility, personal hygiene, and other services of daily living; assistance with light housework, laundry, meal preparation, transportation, grocery shopping, and assistance with health and nutrition maintenance, including assessing well-being and identifying need for medical assistance; complying with nutritional requirements as specified in the Personal Plan; administration of non-prescription medication that are ordinarily self-administered; and administration of prescription medication, when provided by a person legally authorized to assist with the administration of medication.

Self-Management includes assistance with managing safe and responsible behavior; exercising judgment with respect to the member's health and well-being; communication, including conveying information, interpreting information, and advocating in the member's interests; managing money including paying bills, making choices on how to spend money, keeping receipts, and expending funds with the permission of a member's representative payee. Self-management also includes teaching coping skills, giving emotional support, and guidance to other resources the member may need to access.

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The Department is seeking and anticipates receiving CMS approval for this Section. Pending approval, Covered Services will be provided as follows:

29.02 DEFINITIONS (cont.)

Activities that Support Personal Development include teaching or modeling for a member self-care and self-management skills, physical fitness, behavior management; sensory, motor and psychological needs; interpersonal skills to cultivate supportive personal, family, work and

community relationships; resources and opportunities for participation in services to promote social and community engagement; participation in spiritual services of the member's choice; motivating the pursuit of personal development and opportunities; teaching or modeling informed choice by gathering information and practicing decision making; and learning to exercise.

Services that Support Personal Well-being include directly or indirectly intervening to promote the health and well-being of the member. This may include identifying risks such as risk of abuse, neglect or exploitation; participating in a member's risk assessment, identifying and reporting to an immediate supervisor changes in health status and behavior; anticipating or preventing unsafe or destructive behavior; and safely intervening against undesirable behavior according to an intervention plan. In the absence of a plan, intervention must be consistent with DHHS's rule governing emergency intervention and behavioral treatment for persons with intellectual disabilities (14-197 CMR Chapter 5). It may also be necessary to seek emergency medical or safety assistance when needed and comply with reporting requirements.

29.02-12 Employment Setting for either Work Support-Individual or Work Support-Group means a work setting that is integrated with non-disabled employees in a variety of ways. The job must be one that is available to a non-disabled employee with the same expectations for the member's job performance and attendance. The member works under similar work conditions as others without disabilities in similar positions; including access to lunchrooms, restrooms, and breaks. The member performs work duties with ongoing interaction with other workers without disabilities, and has contact with customers, suppliers and the public to the same degree as workers without disabilities in the same or comparable occupations. The member cannot be excluded from participation in company-wide events such as holiday parties, outings and social activities. Staff providing Work Support or Employment Support Services at the worksite are not considered non-disabled employees in determining the level of integration. For those agencies that currently operate under an award from AbilityOne (<http://www.AbilityOne.org>), the federal workforce guidelines associated with this funding source will apply to the services funded by the NISH contract. The member can be on the employer's payroll. Members may receive additional

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The Department is seeking and anticipates receiving CMS approval for this Section. Pending approval, Covered Services will be provided as follows:

29.02 DEFINITIONS (cont.)

employment supports from a provider agency. A member must be supervised in a manner identical to other employees. It is permissible, on a case by case basis to have the support provider offer and provide this supervision as long as the above conditions are met.

- 29.02-13 Exploitation** means the illegal or improper use of an incapacitated or dependent member or that member's resources for another's profit or advantage as defined in 22 MRS §3472.
- 29.02-14 Habilitation** is a service that is provided in order to assist a member to acquire a variety of skills, including self-help, socialization and adaptive skills. Habilitation is aimed at raising the level of physical, mental and social functioning of a member. Habilitation is contrasted to rehabilitation which involves the restoration of function that a person has lost.
- 29.02-15 Instrumental Activities of Daily Living (IADL)** include only the following: main meal preparation; routine housework; grocery shopping and storage of purchased groceries; and laundry either within the residence or at an outside laundry facility.
- 29.02-16 Intellectual Disability (ID)** means a diagnosis as defined in the current edition of the *Diagnostic and Statistical Manual of Mental Disorders* (American Psychiatric Association), that manifested during the developmental period, in accordance with the definition of Intellectual Disability codified in 34-B MRSA §5001.
- 29.02-17 Medical Add On** is an increase in the rate paid to address short or long term medical needs and is approved by the CRT. Medical Add-On is a component of Home Support, Community Support, Employment Specialist Services, Work Support-Individual and is included in the established authorization (as described in Section 29.04-1). It is not a separately billable activity. Billing may not exceed the Home Support, Community Support, Employment Specialist Services, and Work Support-Individual authorized units of service. Documentation must clearly identify and support periods of such activity. Refer to Appendix I for more information.
- 29.02-18 Member** is a person determined to be eligible for MaineCare benefits by the Office for Family Independence (OFI) in accordance with the eligibility standards published by the OFI in the *MaineCare Eligibility Manual*. Some members may have restrictions on the type and amount of services they are eligible to receive.
- 29.02-19 Neglect** means a threat to a member's health or welfare by physical or mental injury or impairment, deprivation of essential needs or lack of protection from these as defined in 22 MRSA §3472.

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The Department is seeking and anticipates receiving CMS approval for this Section. Pending approval, Covered Services will be provided as follows:

29.02 DEFINITIONS (cont.)

- 29.02-20 On Behalf Of** is a billable activity that is provided for individual members and is not necessarily a direct face-to-face service. On Behalf Of is a component of Home Support, Community Support, Employment Specialist Services and Work Support. It is included in the established authorization and is not a separately billable activity. Documentation detail must clearly identify and support periods of such service.
- 29.02-21 Personal Plan** is a member's plan developed at least annually that identifies the services required under the waiver benefit. The Personal Plan must also include services and supports not covered by the waiver but identified by the member. Only covered services included on the Personal Plan are reimbursable. The Personal Plan may also be known as a person centered plan, a service plan, an individual support plan, or an individual education plan, as long as the requirements of Section 29.04 are met.
- 29.02-22 Prior Authorization** is the process of obtaining written prior approval by the Department's Designated Representative as to the medical necessity and eligibility for a service.
- 29.02-23 Qualified Intellectual Disability Professional (QIDP)** is a person who has at least one year of experience working directly with persons with intellectual disabilities or other developmental disabilities and is one of the following: 1) a doctor of medicine or osteopathy; 2) a registered nurse; or 3) an individual who holds at least a bachelor's degree as specified in title 42 *Code of Federal Regulations* (CFR) 483.430, paragraph (B)(5).
- 29.02-24 Qualified Vendor** is a provider approved by DHHS to provide waiver services to eligible members receiving services under this Section. DHHS requires agencies to provide high quality services that, at a minimum, meet the expectations of the members who utilize those services. DHHS may authorize agencies to provide services under this Section after an application, along with supporting documentation, has been submitted to a Designated Representative for review and approval. The Designated Representative will authorize only agencies that meet DHHS expectations in the areas of organization and operation, operation of individual programs or services, personnel administration, environment and safety, and quality management. Only Qualified Vendors will receive DHHS referrals and authorizations for reimbursement.
- 29.02-25 Shared Living (Foster Care-adult)** is a model in which services are provided to a member by a person who meets all of the requirements of a Direct Support Professional with whom that member shares a home. The home may belong to the provider or the member, but the provider must enter into a contractual relationship with an Administrative Oversight Agency in order to provide services under this

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The Department is seeking and anticipates receiving CMS approval for this Section. Pending approval, Covered Services will be provided as follows:

29.02 DEFINITIONS (cont.)

model. Only one member may receive services in any one Shared Living arrangement at the same time, unless a relationship existed prior to the service arrangement and the arrangement is approved by DHHS. In such case, no more than two members may be served in any one Shared Living arrangement concurrently. Please see 29.10-4 for additional qualifications.

29.02-26 Shared Living Provider is a provider who subcontracts with an agency to provide direct support to a member, with whom they share a home. The Shared Living Provider must be a Certified Direct Support Professional (DSP) who has met all the requirements to provide this service. The Shared Living Provider must enter into a contractual relationship with the Administrative Oversight Agency in order to provide services to a member. The agency supports the provider in fulfilling the requirements and obligations agreed upon by the DHHS, the Administrative Oversight Agency, and the member's Personal Plan. See 29.10-4 for additional qualifications.

29.02-27 Utilization Review is a formal assessment of the medical necessity, efficiency and appropriateness of services on a prospective, concurrent or retrospective basis.

29.02-28 Year services are authorized on the state fiscal year, July 1 through June 30.

29.03 DETERMINATION OF ELIGIBILITY

Eligibility for this benefit is based on meeting all three of the following criteria; 1) the member must require Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) level of care as set forth under the *MaineCare Benefits Manual*, Chapter II, Section 50. 2) the member must have eligibility for MaineCare as determined by the DHHS Office for Family Independence (OFI), and 3) a funded opening is available.

29.03-1 Funded Opening- The number of MaineCare members that can receive services under this Section is limited to the number, or "funded openings," approved by the Centers for Medicare and Medicaid Services (CMS) and the appropriation of sufficient funding by the Maine Legislature. Persons who would otherwise be eligible for services under this Section are not eligible to receive services if all of the funded openings are filled or if there is not sufficient funding.

29.03-2 General Eligibility Criteria

Consistent with Subsection 29.03-1, a person is eligible for services under this Section if the person:

- A. Is age eighteen (18) or older; and

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29.03 DETERMINATION OF ELIGIBILITY (cont.)

- B. Has an Intellectual Disability or Autism Spectrum Disorder or Rett Syndrome; and
- C. Meets the medical eligibility criteria for admission to an ICF/IID as set forth under the *MaineCare Benefits Manual*, Chapter II, Section 50; and
- D. Does not receive services under any other federally approved MaineCare Home and Community Based waiver program; and
- E. Meets all MaineCare eligibility requirements as set forth in the *MaineCare Eligibility Manual*; and
- F. The estimated annual cost of the member's services under the waiver is equal to or less than fifty percent (50%) of the state-wide average annual cost of care for an individual in an ICF/IID, as determined by the DHHS.

29.03-3 Establishing Medical Eligibility

In order to determine medical eligibility, the member and case manager must provide to DHHS the following:

- A. A completed copy of the assessment form (BMS99) or current functional assessment approved by the DHHS and
- B. A copy of the member's Personal Plan approved and signed by the member or guardian and the case manager within the preceding six months of the effective plan date and any other relevant material indicating the member's service needs.

Based on review of the Assessment Form, the Personal Plan, a QID designated by DHHS will determine the member's medical eligibility for services under this Section.

DHHS shall notify each member or the member's guardian in writing of any decision regarding the member's medical eligibility, and the availability of benefit openings under this Section. The notice will include information about the member's right to appeal any of these decisions. Rights for notice and appeal are further described in Chapter I of the *MaineCare Benefits Manual*.

The Department is seeking and anticipates receiving CMS approval for this Section. Pending approval, Covered Services will be provided as follows:

29.03 DETERMINATION OF ELIGIBILITY (cont.)

If the member is found to be medically eligible, DHHS must send the member or guardian written notice that the member can receive ICF/IID services or services under this Section. The member or guardian must submit to the case manager a signed Choice letter documenting the member's choice to receive services under this section.

29.03-4 Calculating the Estimated Annual Cost

Prior to formal determination of eligibility for services under this section, each applicant and their planning team must identify the required mix of services to meet the applicant's needs and to assure their health and welfare. The applicant and their planning team shall submit a detailed estimate of the annual cost for waiver services identified in the Personal Plan, including the specific services and the number of units for each service.

29.03-5 Waiting List and Offers for Funded Openings

DHHS will maintain a waiting list of eligible MaineCare members who cannot get access to Section 29 Services because a funded opening is not available. Members who are on the waiting list for the benefit services shall be served chronologically based on the date the Designated Representative determines eligibility for the waiver. At the time when a member is offered a funded opening, the member will be removed from the waiting list.

A member has sixty days from the receipt of notification by DHHS of a funded opening to respond to DHHS with intent to accept waiver services. A member has six months from the receipt of notification to start receipt of services. If the member fails to respond with intent to accept the funded opening within 60 days of this notice or fails to begin services within 6 months, the waiver offer will then be withdrawn. A member may reapply at any time for waiver services.

29.03-6 Redetermination of Eligibility

When making a determination of continuing eligibility, every 12 months from the date of initial approval and every 12 months thereafter, the member's case manager will submit to OADS a current Personal Plan that is less than six (6) months old, and an updated Assessment Form (BMS 99) or current functional assessment approved by the Department.

If the updated Assessment Form and Personal Plan are not received by OADS by the due date, reimbursement for services will be denied until receipt of the assessment form and Personal Plan. Reimbursement for services will resume upon receipt of the Assessment Form and a signed Personal Plan.

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29.04 PERSONAL PLAN

Whenever significant changes occur that alter level of care, the case manager will submit an updated Assessment Form to DHHS. The case manager must complete and submit all waiver documents including the BMS 99, or current functional assessment approved by the Department and the updated Personal Plan to the Resource Coordinator thirty (30) days in advance of the annual redetermination date.

If the member or guardian chooses services under this Section, the request for services must be submitted to DHHS or its Authorized Entity. As part of the planning process, the member's needs are identified and documented in the Personal Plan. Except for residential services, other services shall be provided to the member within ninety (90) days.

29.04-1 Prior Authorization for Reimbursable Services

Medically necessary services and units of services must be identified in the Personal Plan. Requests for services must be submitted to DHHS or its Authorized Agent for Prior Authorization in order for the services to be reimbursed. Requests will be reviewed by DHHS or its Authorized Entity, and may be examined and evaluated by DHHS or its Authorized Entity, before units of service are authorized. All Prior Authorizations are time-limited, and the length of the authorization may vary by member and service as documented in the Personal Plan. Upon expiration of an authorization, a new authorization must be obtained before reimbursement may be provided for the service.

DHHS and its Authorized Entity reserve the right to conduct Utilization Review of any service authorized under this Section, applying the service-specific eligibility standards set forth in this Section. DHHS and its Authorized Entity may terminate or revise a service authorization upon finding that the member no longer satisfies the eligibility standards for the service or level of service authorized.

29.04-2 Personal Plan Requirements

The case manager will ensure that a Planning Team is convened to initiate development of the Personal Plan prior to services being initiated. Case Managers must meet with the member absent of current providers to ensure conflict free planning and informed choice. The planning process must reflect cultural conventions of the member. The planning process must be conducted by providing information in plain language and in a manner that is accessible to the member and when applicable, their legal representative.

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29.04 PERSONAL PLAN (cont.)

The effective plan date must be current and less than six (6) months old at the time of the member's eligibility determination or redetermination. The planning process must comply with the requirements described in 42 CFR §441.301 (c)(1), and 34-B M.R.S.A. §5470-B(2).. The Personal Plan must contain at a minimum:

- A. All MaineCare Home and Community waiver benefit services determined medically necessary by the team including all other services that may not be covered under this section but that the member identifies and may pursue;
- B. The frequency of provision of the services, including transportation services;
- C. How services contribute to the member's health and well-being and the member's ability to reside in a community setting;
- D. The member's goals for strengthening and cultivating personal, community, family, and professional relationships;
- E. The role and responsibility of the member's service providers in supporting the member's goals, including goals for strengthening natural and supportive personal, family, community and professional relationships;
- F. Members who chose to receive Home Support- Remote Support must have a safety/risk plan, which shall describe the potential risks to the member's health and welfare while receiving Home Support- Remote Support and the reasonable steps to alleviate those risks; and
- G. In order for the Personal Plan to be approved, the Personal Plan must include signatures of
 - 1. The member,
 - 2. The guardian, if applicable,
 - 3. The case manager, and
 - 4. Per 34-B MRSA §5470-B and 42 CFR §441.301, the individuals and providers responsible for the implementation of the plan.

The Personal Plan will be used by DHHS or its Authorized Entity to identify the type and units of authorized services the member may receive under this Section. If more than one provider is reimbursed for the same category of direct supports, an

The Department is seeking and anticipates receiving CMS approval for this Section. Pending approval, Covered Services will be provided as follows:

29.04 PERSONAL PLAN (cont.)

explanation of the differences in roles and responsibilities of each provider and how services will not be duplicated is required.

All providers must ensure that notice of the Grievance process outlined in 14-197 CMR Chapter 8 is regularly provided to members served by the provider. Providing notice includes, at a minimum, ensuring that written notice of the grievance process is provided to the member and/or their guardian at any planning meeting; posting notice of the grievance process in an appropriate common area of all facilities operated by the provider; and posting notice of the grievance process on any website maintained by the provider. In addition, the provider must ensure that all staff are trained in the grievance process.

29.04-3 Planning Team Composition

Each member or guardian will determine the composition of the Planning Team. Planning will occur in a manner that is respectful and reflective of the member's preference. The member will lead the person-centered planning process where possible. The member's representative should have a participatory role, as needed and as defined by the member, unless State law confers decision-making authority to the legal guardian.

The Case Manager is responsible for convening the planning team and facilitating the Person Centered Planning process. The Case Manager or Case Management Supervisor has sole authority for scheduling and rescheduling the planning team at the request of the member or their legal representative. In addition to the Case Manager,

The planning team must include the following members, if applicable:

- A. The member;
- B. The member's guardian; and
- C. An approved Correspondent through the Maine Developmental Services Oversight and Advisory Board;

The planning team may include the following members, if applicable:

- A. The member's advocate or friend or any additional individual invited by the member;
- B. Direct Support Professionals providing services to the member;

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29.04 PERSONAL PLAN (cont.)

- C. Staff from the member's providers; and
- D. Any professionals involved or likely to be involved with the member's Personal Plan.

29.04-4 Updating the Personal Plan

The member's Personal Plan must be revised and updated at least annually, based on the plan's effective date or at the request of the member or guardian, and in addition when other significant changes occur relating to the member's physical, social, behavioral, medical, communication, or psychological needs, or the member's significant progress toward his or her goals.. The Case Manager must reconvene the Planning Team to revise and update the Personal Plan as service needs change, including the location where services are received. Planning meetings must be held both prior to 30 days and subsequent to the planned move of a member to a new service in order to coordinate and to evaluate the member's satisfaction with the change.

29.05 COVERED SERVICES

29.05-1 Assistive Technology- Assistive technology device means an item, piece of equipment, or product system, whether acquired commercially, modified, or customized, that is used to increase, maintain, or improve functional capabilities of members. Assistive technology service means a service that directly assists a member in the selection, acquisition, or use of an assistive technology device.

If authorized, the Department expects that Home Support-Remote Support Hours will be implemented within 90 days of assessment.

Assistive Technology includes;

(A) Assistive Technology-Assessment:

1. The evaluation of the assistive technology needs of a member, including a functional evaluation of the impact of the provision of appropriate assistive technology and appropriate services to the member in the customary environment of the member;
2. The coordination and use of necessary therapies, interventions, or services with assistive technology devices, such as therapies, interventions, or services associated with other services in the service plan;

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29.05 COVERED SERVICES (cont.)

3. The training or technical assistance for the member, or, where appropriate, the family members, guardians, advocates, or authorized representatives of the member; and
4. The training or technical assistance for professionals or other individuals who provide services to, employ, or are otherwise substantially involved in the major life functions of members.

Assistive Technology-Assessment is subject to a combined limit per year. See Section 29.07 below.

(B) Assistive Technology-Devices:

1. The purchasing, leasing, or otherwise providing for the acquisition of assistive technology devices for members; and
2. The selecting, designing, fitting, customizing, adapting, applying, maintaining, repairing, or replacing assistive technology devices.

Assistive Technology-Devices is subject to a combined limit per year. See Section 29.07 below.

(C) Assistive Technology-Transmission (Utility Services); the transmission of data required for use of the Assistive Technology Device via internet or cable utility. Assistive Technology-Transmission is subject to a combined limit per month. See Section 29.07-16.

29.05-2 Career Planning is a person centered, comprehensive direct support. Career Planning assists with identifying a career direction and developing a plan for achieving competitive, integrated, individual employment or self-employment at or above the State's minimum wage. Services assist in identifying skills, priorities, and capabilities determined through an individualized discovery process. A Department approved Career Planning curriculum may include a referral to benefits planning, referral of assessment for use of assistive technology to increase independence in the workplace, and development of experiential learning opportunities and career options consistent with the member's skills and interests. Career Planning may be used in preparation to gather information for a referral to Vocational Rehabilitation.

Career Planning is limited to 60 hours annually, to be delivered in a six-month period. No two six-month periods may be provided consecutively. In order to receive Career Planning services, the member's Personal Plan must identify the need to

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29.05 COVERED SERVICES (cont.)

explore work, identify career direction and describe how the Career Planning services will be used to achieve those goals.

The service requires submission of the Career Plan at 3 intervals to DHHS in order to ensure that the service is provided in a manner that will result in competitive, integrated employment or self-employment at or above the current minimum wage.

Career Planning services can be provided within a variety of community settings such as a Career Center, the community and local business and must be documented in the Personal Plan with related goals.

The cost of Transportation related to the provision of Career Planning is a component of the rate paid for the service.

29.05-3 Community Support is provided by a Direct Support Professional employed by an OADS approved provider in order to increase or maintain a member's ability to successfully engage in inclusive social and community relationships and to maintain and develop skills that support health and well-being. This is a habilitative service with a focus on community inclusion, personal development, and support in areas of daily living skills if necessary.

Community Support is intended to be flexible, responsive and provided to members as defined by the member's choice and needs as documented in the member's personal plan. The location of the service and staffing level may vary, allowing for a mix of individualized and group services.

Community Support allows for opportunities for career exploration and the facilitation of discussions about the benefits of working. Activities and discussions related to work should be relevant to identifying a member's employment interests, their individual strengths as related to employment, employment goals and the conditions necessary for the member to achieve and maintain successful employment.

The average staff to member ratio for Community Support for each program location must not exceed 1:3.

Nothing in this rule prohibits one-to-one (1:1) service delivery.

"On Behalf of" is a component of Community Support; and is included in the established authorization and is not a separate billable service.

A member may not receive Community Support while enrolled in high school. A member may not receive Community Support at his or her place of employment.

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29.05 COVERED SERVICES (cont.)

The cost of transportation related to the provision of Community Support is a component of the rate paid for the service and is not separately billable. For specific limits of this service see 29.07.

Within the scope of Community Support, there may be activities that require that the service be provided in the member's home; this will involve the origination or termination of the Community Support Service. This is allowable as long as it does not duplicate Home Support.

29.05-4 Employment Specialist Services include services necessary to support a member in maintaining Employment. Services include: (1) periodic interventions on the job site to identify a member's opportunities for improving productivity, minimizing the need for formal supports by promoting natural workplace relationships, adhering to expected safety practices, and promoting successful employment and workplace inclusion; (2) assistance in transitioning between employers when a member's goal for type of employment is not substantially changed, including assistance identifying appropriate employment opportunities and assisting the member in acclimating to a new job; (3) Employment Specialist Services for job development, if Vocational Rehabilitation denies services under the *Rehabilitation Act* and the member is unable to benefit from Vocational Rehabilitation. If Employment Specialist Services are used for job development, current documentation of ineligibility from Vocational Rehabilitation is required.

Employment Specialist Services are provided by an Employment Specialist who may work either independently or under the auspices of a Supported Employment provider but must have completed the approved Employment Specialist training as outlined by DHHS in order to provide Employment Specialist Services. The need for continued Employment Services must be documented in a member's Personal Plan as necessary to maintain employment over time.

Employment Specialist Services are provided at work locations where non-disabled individuals are employed as well as in entrepreneurial situations. Employment Specialist Services may be utilized to assist a member to establish and or sustain a business venture that is income producing. MaineCare funds may not be used to defray the expenses associated with the start up or operating a business.

"On Behalf of" will continue as a component of Employment Specialist Service; and is included in the established authorization and is not a separate billable service.

The cost of transportation related to the provision of Employment Specialist Services is a component of the rate paid for the service.

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29.05 COVERED SERVICES (cont.)

Employment Specialist Services are provided on an intermittent basis with a maximum of 10 (ten) hours each month.

Nothing in this rule prohibits a member from working under a Special Minimum Wage Certificate issued by the Department of Labor under the *Fair Labor Standards Act*.

Employment Specialist Services cannot be provided at the same time as Work Support-Group or Work Support-Individual.

29.05-5 Home Accessibility Adaptations are those physical adaptations to the private residence of the member or the member's family, required by the member's Personal Plan, that are necessary to ensure the health, welfare and safety of the member or that enable the member to function with greater independence in the home.

Adaptations must not be covered under state plan services, including Section 60, Medical Supplies and Durable Medical Equipment of the *MaineCare Benefits Manual* and must be determined medically necessary as documented by a licensed physician and approved by DHHS Office of Aging and Disability Services (OADS). Adaptations commonly include:

- Bathroom modifications
- Widening of doorways
- Light, motion, voice and electronically activated devices
- Fire safety adaptations
- Air filtration devices
- Ramps and grab-bars
- Lifts (can include Barrier-free track lifts)
- Specialized electric and plumbing systems for medical equipment and supplies
- Lexan windows (non-breakable for health & safety purposes)
- Specialized flooring (to improve mobility and sanitation)

Items not included above but which have been recommended in a Personal Plan are subject to approval by the DHHS for reimbursement.

Excluded are those adaptations or improvements to the home that are of general utility, and are not of direct medical or remedial benefit to the member. Adaptations that add to the total square footage of the home are excluded from this benefit except when necessary to complete an adaptation (e.g. in order to improve entrance/egress to a residence or to configure a bathroom to accommodate a wheelchair). In-floor radiant heating is not allowable. General household repairs are not included in this service. All services shall be provided in accordance with applicable State or local

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29.05 COVERED SERVICES (cont.)

building codes. All providers must be appropriately licensed or certified in order to perform this service. This service applies to member owned or a member's family owned home only. Provision of this service in a property owned, rented or leased by an agency is acceptable as long as the adaptation is portable and is the property of the member.

The limit for adaptations is ten thousand dollars (\$10,000) in a five (5) year period, with an additional annual allowance up to three hundred dollars (\$300) for repairs and replacement per year. All items in excess of five hundred dollars (\$500) require documentation from a physician or other appropriate professionals such as OT, PT or Speech therapists that the purchase is appropriate and medically necessary to meet the member's need. Medically necessary home modifications that cannot be obtained as a covered service under any other MaineCare benefit may be reimbursed under this section if they meet all requirements of this Section.

29.05-6 Home Support-Quarter Hour is direct support (billed per unit) provided in the member's home, by a Direct Support Professional to improve and maintain a member's ability to live as independently as possible. Home Support is direct support to a member and includes primarily habilitative training and/or personal assistance with ADLs and/or IADLs, development and personal well-being.

Within the scope of Home Support, there may be activities that require that the service be carried over into the community. Nothing in this rule is intended to prohibit community inclusion as a reimbursable service accompanied by documentation on the Personal Plan provided that the service has a therapeutic outcome. An example is shopping for food, which may later be prepared in the home. This is allowable as long as it does not duplicate Community Support.

Home Support cannot be provided at a Member's employment site.

On Behalf Of is a component of Home Support and is included in the established authorization and is not a separate billable activity. The cost of transportation related to the provision of Home Support is a component of the rate paid for the service and is not separately billable.

There is no overlap between Assistive Technology and Home Support Remote Support. Assistive Technology provides for the assessment, the equipment and the cost of the monthly transmission. Home Support-Remote Support provides the staff who are monitoring the member.

29.05-7 Home Support-Remote Support- This service provides real time, remote communication and support through a wide range of technological options including

The Department is seeking and anticipates receiving CMS approval for this Section. Pending approval, Covered Services will be provided as follows:

29.05 COVERED SERVICES (cont.)

electronic sensors, video conferencing, environmental sensors (movement, doors, temperature, smoke, CO, etc.), video cameras, microphones and speakers, as well as health monitoring equipment. This assistive technology links each member's residence to the Remote Support provider.

The Remote Support provider has staff available 24 hours per day 7 days per week to deliver direct 1:1 care when needed. If a member chooses this service, the member's Personal Plan must include a safety/risk plan that identifies at least two levels of emergency back-up.

The use of this service is based upon the member's assessed needs and the resulting Personal Plan. The Personal Plan reflects the member's consent and commitment to the plan elements including all assistive communication, environmental control and safety components. An Assistive Technology Assessment must be completed by a qualified consultant prior to the finalization of the Personal Plan by the case manager and the member with the assistance of the Planning Team to ensure the appropriateness of assistive technology.

All Remote Support Services must be provided in real time.

All electronic systems must have back-up power connections to insure functionality in case of loss of electric power. Providers must comply with all federal, state and local regulations that apply to its business including but not limited to the "*Electronic Communications Privacy Act of 1986*". Any services that use networked services must comply with HIPAA requirements.

There is no overlap between Assistive Technology and Home Support Remote Support. As set forth in §29.05-1, Assistive Technology may be used to provide for assessments, equipment, and the cost of the monthly data transmission utility necessary to facilitate Home Support-Remote Support services. Home Support-Remote Support provides the staff monitor the member.

There are two types of Remote Support: Interactive Support and Monitor Only. Chapter III reflects the billing for each type. Interactive Support includes only the time that staff is actively engaging a member in 1 to 1 direct support through the use of the Assistive Technology Device. Monitor Only is when Assistive Technology equipment is being used to monitor the member without interacting.

29.05-8 Respite Services provided to members unable to care for themselves that are furnished on a short-term basis because of the absence or need for relief of those persons who normally provide care for the member. Respite may be provided in the

The Department is seeking and anticipates receiving CMS approval for this Section. Pending approval, Covered Services will be provided as follows:

29.05 COVERED SERVICES (cont.)

member's home, provider's home or other location as approved by a respite agency or DHHS (for example, a motel in the case of an emergency).

29.05-9 Shared Living (Foster Care, Adult)-is direct support billed per diem and includes; personal care, protective oversight and supervision and supportive services (e.g., homemaker, chore, attendant care, companion, medication oversight (to the extent permitted under State law)) provided in a private home by a principal care provider who lives in the home and is a Direct Support Professional. Residential habilitation means individually tailored supports that assist with the acquisition, retention, or improvement in skills related to living in the community. These supports include adaptive skill development, assistance with activities of daily living, community inclusion, transportation, adult educational supports and social and leisure skill development that assist the member to reside in the most integrated setting appropriate to the member's needs.

For this Service, respite is a component of the rate paid to the Administrative Oversight Agency and therefore is not a separate billable service. The record must accurately reflect the member's location during the receipt of respite.

Only one member may receive services in any one Shared Living arrangement at the same time, unless a relationship existed prior to the service arrangement and the arrangement has been approved by DHHS. In such case, no more than two members may be served in any one Shared Living arrangement concurrently.

29.05-10 Transportation Service is offered in order to enable members to gain access to Section 29 services, as specified by the Personal Plan. Transportation services for Section 29 services are provided under the *MaineCare Benefits Manual*, Section 113 (Non-Emergency Medical Transportation Services).

Whenever possible, family, neighbors, friends, or community agencies, which can provide this service without charge, are utilized.

A provider may only be reimbursed for providing transportation services when the cost of transportation is not a component of a rate paid for another service.

29.05-11 Work Support-Group is Direct Support provided to improve a member's ability to independently maintain employment. Work Support-Group comprises services and training activities that are provided in regular business, industry and community settings for groups of two to six members. Mobile work crews, and business based workgroups (enclaves) employing small groups of workers in employment in the community are examples of the models allowed. Work Support-Group must be demonstrably structured and provided in a manner that

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29.05 COVERED SERVICES (cont.)

promotes the integration into the workplace and interaction between members and people without disabilities in those workplaces. The primary focus of the support is job related and also encompasses adherence to workplace policies, safety, productivity, dress code, work schedule, building co-worker and supervisor relationships, hygiene and self-care.

To receive this service, a member must have received an assessment and services under the *Americans with Disabilities Act*, and Section 504 of the *Rehabilitation Act* and need for on-going support must have been determined and documented in the Personal Plan. The outcome of this service must be sustained paid employment and work experience leading to further career development and individual integrated community based employment for which the member is compensated at or above the minimum wage, and not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities. Work Support-Group does not include vocational services provided in a facility-based work setting in specialized facilities that are not part of the general workforce.

Work Support-Group may be used to support a member in a job that pays less than the minimum wage only if the employer complies with section 14(c) of the *Fair Labor Standards Act* (29 U.S.C. §214(c)) and 26 M.R.S. §666.

Documentation must be maintained in the file of each member receiving this service that the service is not available under a program funded under section 110 of the *Rehabilitation Act of 1973* or the *Individuals with Disabilities Education Act* (20 U.S.C. 1401 *et seq.*).

Work Support-Group does not include volunteer work.

Work Support-Group cannot be used to cover incentive payments, subsidies, or unrelated vocational training expenses such as the following: 1) Incentive payments made to an employer to encourage or subsidize the employer's participation in a supported employment program; 2) Payments that are passed through to users of supported employment programs; or 3) Payments for training that is not directly related to an individual's supported employment program.

The cost of transportation related to the provision of Work Support-Group is a component of the rate paid for the service.

No more than six (6) members at one time may be supervised by a Direct Support Professional. The appropriate group rate must be billed.

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29.05 COVERED SERVICES (cont.)

The provider will submit a group work site schedule to the OADS Resource Coordinator listing members, work sites, units of service and staff. The provider will submit schedules quarterly thereafter to the Resource Coordinator.

Information must be provided to the member at least yearly that career planning and individual employment are available to them in order to make an informed decision.

29.05-12 Work Support-Individual is Direct Support provided to improve a member’s ability to independently maintain employment. Work Support-Individual is provided in a member’s place of but may be provided in a member’s home in preparation for work if it does not duplicate services already reimbursed as Home Support, Community Support or Employment Specialist Services.

Work Support-Individual must be provided to the member in an integrated employment setting in the general workforce and the member must be compensated at or above the minimum wage, and not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities.

This service is provided after a member has received an assessment and services under the *Americans with Disabilities Act* and Section 504 of the *Rehabilitation Act* and need for on-going support has been determined and documented in the Personal Plan. Work Support-Individual may be provided to self-employed members where the member requires support in operating his or her own business. Support may be used for Customized employment for members with severe disabilities – to include long term support to successfully maintain a job due to the ongoing nature of the member’s support needs, changes in life situation, or evolving and changing job responsibilities. The primary focus of the support is job related and also encompasses adherence to workplace policies, safety, productivity, dress code, work schedule, building co-worker and supervisor relationships, hygiene and self-care.

Work Support-Individual does not include volunteer work.

“On Behalf of” is a component of Work Support-Individual and is included in the established authorization and is not a separate billable service.

Documentation must be maintained in the file of each member receiving this service that the service is not available under a program funded under section 110 of the *Rehabilitation Act of 1973* or the *Individuals with Disabilities Education Act* (20 U.S.C. 1401 *et seq.*).

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The Department is seeking and anticipates receiving CMS approval for this Section. Pending approval, Covered Services will be provided as follows:

29.05 COVERED SERVICES (cont.)

Work Support-Individual cannot be used to cover incentive payments, subsidies, or unrelated vocational training expenses such as the following: 1) Incentive payments made to an employer to encourage or subsidize the employer's participation in a supported employment program; 2) Payments that are passed through to users of supported employment programs; or 3) Payments for training that is not directly related to an individual's supported employment program.

The cost of transportation related to the provision of Work Support is a component of the rate paid for the service.

29.06 NON COVERED SERVICES

Services for which reimbursement is not allowed under this Section include, but are not limited to, the following:

- 29.06-1** Services not identified by the Personal Plan;
- 29.06-2** Services to any MaineCare member who receives services under any other federally approved MaineCare Home and Community based waiver program;
- 29.06-3** Services to any member who is a nursing facility resident, or ICF/IID resident, psychiatric hospital resident, or hospital resident;
- 29.06-4** Services that are reimbursable under any other sections of the *MaineCare Benefits Manual*;
- 29.06-5** Any service otherwise reimbursable under the *Rehabilitation Act of 1973* or the *Individuals with Disabilities Education Act*, including but not limited to job development and vocational assessment or evaluations;
- 29.06-6** Room and board; The term "room" means shelter type expenses, including all property related costs such as rental or purchase of real estate and furnishings, maintenance, utilities, and related administrative services. The term "board" means three meals a day; or any other full nutritional regimen. Board does not include the provision of a meal at an adult day health or similar facility outside the member's home. Board also does not include the delivery of a single meal to a member at his/her own home through a meals-on-wheels service;
- 29.06-7** Work Support-Individual or Work Support-Group or Employment Specialist Services when the member is not engaged in employment;

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The Department is seeking and anticipates receiving CMS approval for this Section. Pending approval, Covered Services will be provided as follows:

29.06 NON COVERED SERVICES (cont.)

- 29.06-8** Home Accessibility Adaptations unless the service has been determined non reimbursable under Medical Supplies and Durable Equipment, Section 60 or other sections of the *MaineCare Benefits Manual*;

- 29.06-9** A member may not have wages from employment paid for with MaineCare reimbursement: and

- 29.06-10** Services provided directly or indirectly by the legal guardian will not be reimbursed unless the legal guardian is the member's parent, sibling or other biological family member. This rule will not be avoided by adult adoption.

29.07 LIMITS

- 29.07-1** MaineCare members can receive services under only one Home and Community Waiver Benefit at any one time.

- 29.07-2** The combined annual limit for members who receive Home Support (Remote or ¼ hour), Community Support, or Shared Living, is fifty two thousand, four hundred and twenty five dollars (\$52,425.00). This cap will be retroactive to July 1, 2017.

- 29.07-3** Employment Specialist Services are provided on an intermittent basis with a maximum of ten (10) hours (forty (40) quarter hour units) each month.

- 29.07-4** Home Accessibility Adaptations are limited to ten thousand dollars (\$10,000) in a five (5) year period with an additional annual allowance up to three hundred dollars (\$300) for repairs and replacement per year. General household repairs are not included in this service. All items in excess of five hundred (\$500) dollars require documentation from physician or other appropriate professional such as OT, PT or Speech therapist that purchase is appropriate to meet the member's need. Medically necessary home modifications that cannot be obtained as a covered service under any other MaineCare benefit can be reimbursed under this section.

- 29.07-5** A provider may only be reimbursed for providing transportation services when the cost of transportation is not a component of a rate paid for another service.

- 29.07-6** Respite Services are limited to one thousand one hundred dollars (\$1100.00) per year. This respite cap will be effective retroactive to July 1, 2017. Additionally, the quarter hour (1/4) billing for Respite shall not exceed the per diem limit of (Ninety dollars (\$90.00) for each date of service. Reimbursement for Respite is a quarter (1/4) hour billing code. After thirty three (33) quarter hour units of consecutive Respite Services, the provider must bill using the per diem billing code.

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29.07 LIMITS (cont.)

The quarter hour (1/4) Respite amount billed any single day cannot exceed the Respite per diem rate of Ninety (\$90.00) dollars.

- 29.07-7** Services reimbursed under this section are not available to members who reside in an ICF/IID, nursing facility or are inpatients of a psychiatric hospital or hospital.
- 29.07-8** **Duplicative Services.** A member may not receive services that are comparable or duplicative under another Section of the *MaineCare Benefits Manual* at the same time as services provided under this waiver benefit. Such comparable or duplicative services include, but are not limited to services covered under the *MaineCare Benefits Manual*, Section 2, Adult Family Care Services; Section 18, Home and Community Based Services for Adults with Brain Injury; Section 19, Home and Community Benefits for the Elderly and for Adults with Disabilities; Section 20, Home and Community Based Services for Adults with Other Related Conditions; Section 21, Home and Community Benefits for Person with Intellectual Disabilities or Autism Spectrum Disorder; Section 28, Rehabilitative and Community Support Services for Children with Cognitive Impairments and Functional Limitations; Section 45, Hospital Services; Section 46, Psychiatric Facility Services; Section 50, ICF/IID Services; Section 67, Nursing Facility Services and Section 97, Private Non-Medical Institution Services.
- 29.07-9** A member may not receive Community Support while enrolled in high school. A member may not receive Community Support at his or her place of employment.
- 29.07-10** A member may not receive Employment Specialist Services while enrolled in high school.
- 29.07-11** Work Support Services are limited to one Direct Support Professional per member at a time.
- 29.07-12** The total amount of Services authorized may not exceed 50% of the state-wide average annual cost of care for an individual in an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID), as determined by the Department.
- 29.07-13** If a current waiver recipient enters a nursing facility or a hospital, payment under the waiver will be temporarily suspended. If the waiver recipient remains in the nursing facility or hospital for more than thirty (30) consecutive days, enrollment in this waiver will be terminated unless there is a written request to the Department to continue holding the funded opening.
- 29.07-14** Assistive Technology services are not covered under this rule if they are available under another MaineCare rule.

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The Department is seeking and anticipates receiving CMS approval for this Section. Pending approval, Covered Services will be provided as follows:

29.07 LIMITS (cont.)

Assistive Technology services are subject to the following limits:

- A. Assistive Technology-Assessment is subject to a combined limit of 32 units (8 hours) per year.
- B. Assistive Technology-Devices, including the selecting, fitting, customizing, adapting, applying, maintaining, repairing or replacing of assistive technology devices, is subject to a combined limit of \$6,000 per year.
- C. Assistive Technology-Transmission (Utility Services) is subject to a combined limit of \$50 per month.

29.07-15 Career Planning is limited to 60 hours to be delivered in a six-month period. No two six-month periods may be provided consecutively.

29.07-16 Out of State Services Authorizations for services to be provided out of state will not exceed sixty (60) days of service within a given fiscal year and will not exceed sixty (60) days within any six (6) month period except as provided in 42 C.F.R. §431.52(b).

29.08 DURATION OF CARE

Each member receiving services under this Section is eligible for as many covered services as are authorized by DHHS in the member's personal plan. Services are authorized to meet the needs identified in the member's most recent assessment, subject to limits on covered service components specified elsewhere in this Section.

29.08-1 Voluntary Termination- A member who currently receives the benefit, but no longer wants to receive the benefit, will be terminated, after DHHS receives written notice from the member that he or she no longer wants the benefit.

29.08-2 Involuntary Termination-DHHS will give written notice of termination to a member at least ten (10) days prior to the effective date of the termination, providing the reason for the termination, and the member's right to appeal such decision. A member may be terminated from this benefit for any of the reasons listed below:

- A. The member is determined to be financially or medically ineligible for this benefit or MaineCare;
- B. The member is determined to be a nursing facility resident, psychiatric hospital, hospital, or ICF/IID resident for six months;

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*The Department is seeking and anticipates receiving CMS approval for this Section. Pending approval,
Covered Services will be provided as follows:*

29.08 DURATION OF CARE (cont.)

- C. The member is determined to be receiving MaineCare services from another Home and Community Based Waiver benefit;
- D. The member is no longer a resident of the State of Maine;
- E. The health and welfare of the member can no longer be assured because:
 - 1. The member or immediate family, guardian or caregiver refuses to abide by the Personal Plan or other benefit policies;
 - 2. The home or home environment of the member becomes unsafe to the extent that benefit services cannot be provided without risk of harm or injury to the member or to individuals providing covered services to the member; or
 - 3. There is no approved Personal Plan.
- F. The member has not received at least one waiver service in a thirty (30) day period; or
- G. The annual cost of the member's services under this waiver exceeds fifty percent (50%) of the state-wide average annual cost of care for an individual in an ICF/IID, as determined by the DHHS.

29.08-3 Provider Termination from the MaineCare program- The provider must provide the member and DHHS thirty (30) days written notice prior to the effective date of termination.

29.08-4 After a member is determined eligible for this waiver, if there is any one (1) month period during which the member does not receive a waiver service, the case manager must include a note in the record indicating;

- A. The reason a waiver service was not provided,
- B. Whether the member continues to need services provided in the waiver.

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29.09 MEMBER RECORDS

Each provider serving the member must maintain a specific record for each member it serves in accordance with the requirements of Chapter I of the *MaineCare Benefits Manual*. The member's record is subject to DHHS's review.

In addition, the member's records must contain:

- A. The member's name, address, birth date, MaineCare identification number, guardian contacts and emergency contacts;
- B. The member's social and medical history, including allergies and diagnoses;
- C. The member's Personal Plan; and
- D. Written progress notes that identify any actions related to progress towards the achievement of the goals, services and needs established by the member's Personal Plan signed by the staff performing the service.

DHHS will conduct a review of provider records that may include, but is not limited to, staff schedules, payroll records and member records to substantiate service delivery and units of authorization.

29.10 PROVIDER QUALIFICATIONS AND REQUIREMENTS

The provider must document each service provided, the date of each service, the type of service, need or goal to which the service relates, the length of time of the service, and the signature of the individual performing the service.

To provide services under this section a provider must be a qualified vendor as approved by DHHS and enrolled by the MaineCare program. Once a provider has been authorized to provide services, the provider cannot terminate the member's services without written authorization from DHHS.

Providers must ensure staff are trained in identifying risks, such as risk of abuse, neglect or exploitation; participating in a member's risk assessment; identifying and reporting to an immediate supervisor changes in health status and behavior; anticipating or preventing unsafe or destructive behavior; and safely intervening against undesirable behavior according to an intervention plan. Any plan, intervention must be consistent with the DHHS's rule governing emergency intervention and behavioral treatment for persons with intellectual disabilities (14-197 CMR Chapter 5). It may also be necessary to seek emergency medical or safety assistance when needed and comply with Reportable Events reporting requirements.

All staff, regardless of length of employment, must have Behavioral Regulations (14-197 CMR, Chapter 5), Regulations Regarding Reportable Events, Adult Protective Investigations and

The Department is seeking and anticipates receiving CMS approval for this Section. Pending approval, Covered Services will be provided as follows:

29.10 PROVIDER QUALIFICATIONS AND REQUIREMENTS (cont.)

Substantiation Hearings Regarding Persons with Mental Retardation and Autism (14-197, ch12), and Rights of Persons with Intellectual Disabilities or Autism Training (Title 34-B §5605). These trainings are required every thirty six (36) months. Documentation of training must be maintained in provider personnel files,

Additional information regarding provider requirements can be found in APPENDIX IV- Additional Requirements for Section 29 Providers Community Support Services and Employment Specialist Services.

29.10-1 Direct Support Professional (DSP)

The following requirements apply to DSPs:

- A. DSPs must successfully complete the Direct Support Professional curriculum as adopted by DHHS, or DHHS's approved Assessment of Prior Learning, or successfully complete the Maine College of Direct Support within six (6) months of date of hire.
- B. Prior to providing services to a member alone, a DS must complete the following four modules from the College of Direct Support, including computer based and live sessions:
 - 1. Introduction to Developmental Disabilities
 - 2. Professionalism
 - 3. Individual Rights and Choice
 - 4. Maltreatment

Documentation of completion must be retained in the personnel record.

- C. DSPs must complete the following Department approved trainings within the first six (6) months from date of hire and thereafter every thirty six (36) months:
 - 1. Regulations Regarding Reportable Events, Adult Protective Investigations and Substantiation Hearings (14-197, Ch. 12)
 - 2. Regulations Governing Behavioral Support, Modification and Management for People with Intellectual Disabilities or Autism in Maine (14-197, Ch. 5)

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The Department is seeking and anticipates receiving CMS approval for this Section. Pending approval, Covered Services will be provided as follows:

29.10 PROVIDER QUALIFICATIONS AND REQUIREMENTS (cont.)

3. Rights and Basic Protections of a Person with an Intellectual Disability or Autism (Title 34-B §5605)
 4. Grievance Training (14-197, ch. 8). This training must be completed before working with members.
- D. DSPs must have a background check completed consistent with Section 29.10-4.
- E. DSPs must have an adult protective and child protective record check.
- F. DSPs must be at least eighteen (18) years of age.
- G. DSPs must have graduated from high school or acquired a GED.
- H. DSPs must have current CPR and First Aid Certification.
- I. A DSP is legally authorized to assist with the administration of medication if the DSP is certified as a Certified Nursing Assistant-Medications (CNA-M); as a Certified Residential Medication Aide (CRMA), or a Registered Nurse (RN), or otherwise has been trained to administer medications through a training program specifically for Shared Living model homes and authorized, certified, or approved by DHHS.
- J. A DSP who also provides Work Support- Individual or Work Support-Group must have completed the additional employment modules in the Maine College of Direct Support in order to provide services.
- K. A DSP who also provides Career Planning must have completed the additional employment modules in the Maine College of Direct Support and an additional twelve (12) hours of Career Planning and Discovery training provided through Maine's Workforce Development System.
- L. All new staff or subcontractors must complete the Maine College of Direct Support within six (6) months of actual employment from date of hire. Evidence of date of hire and enrollment in the training must be documented in writing in the employee's personnel file or a file for the subcontractor. Services provided during this time are reimbursable as long as the documentation exists in the personnel file.

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29.10 PROVIDER QUALIFICATIONS AND REQUIREMENTS (cont.)

- M. A person who provides Direct Support must be a DSP regardless of his or her status as an employee or subcontractor of an agency. A DSP can supervise another DSP.
- N. Only a DSP who is certified as a Certified Nursing Assistant-Medications (CNA-M), a Certified Residential Medication Aide (CRMA), or a Registered Nurse (RN) may administer medications to a member.
- O. A DSP may supervise another DSP.

29.10-2 Employment Specialist is a person who provides Employment Specialist Services or Work Support. The following requirements apply to Employment Specialists:

- A. Employment Specialists must Successfully complete the Maine Employment Curriculum for Employment Specialist Certification as approved by DHHS. (approved courses are listed at: <http://www.employmentforme.org/providers/crp-training.html>) Certification must occur within six (6) months of hire.
- B. Employment specialists must be supervised during the first six months of hire by a Certified Employment Specialist in order to provide services.
- C. Employment Specialists must have graduated from high school or acquired a GED.
- D. Staff can either be certified as an Employment Specialist or complete the Approved Direct Support Curriculum along with additional modules specific to employment.
- E. Employment Specialists must have satisfied a background check consistent with Section 29.10-4.
- F. Employment Specialists must have worked for a minimum of one (1) year with a person or persons having an Intellectual Disability or Autism Spectrum Disorder in a work setting.
- G. An Employment Specialist who also provides Career Planning must have completed the additional twelve (12) hours of Career Planning and Discovery provided through Maine's Workforce Development System and six (six) hours of Department approved continued education every twelve (12) months.

The Department is seeking and anticipates receiving CMS approval for this Section. Pending approval, Covered Services will be provided as follows:

29.10 PROVIDER QUALIFICATIONS AND REQUIREMENTS (cont.)

29.10-3 Emergency Intervention- All providers must follow DHHS's rule governing emergency intervention and behavioral treatment for persons with Intellectual Disabilities (14-197 CMR Chapter 5), and must meet training requirements on approved behavioral interventions procedures (e.g., Mandt) if applicable and indicated as a need in the member's Personal Plan.

29.10-4 Shared Living (Foster Care, Adult)

The Shared Living Home Provider maintains a supportive home environment that promotes community inclusion with an appropriate level of support and supervision.

The Shared Living Home Provider is required to: Maintain a clean and healthy living environment addressing any necessary member-specific environmental or safety standards (see Appendix IV).

- A. Attend to the member's physical health and emotional well-being.
- B. Participate as a part of the member's Person-Centered Planning Team and maintain open communication with the Case Manager, Administrative Oversight Agency, guardian and Person-Centered Planning Team.
- C. Assist in transition, admission, or discharge plans.
- D. Include the member in family and community life, assisting the member to develop healthy relationships and increased community independence.
- E. Provide community access to services and activities desired by the member but not limited to; religious affiliation (if desired), physical activities, shopping, volunteering, etc.
- F. Maintain professional daily documentation in accordance with MaineCare requirements.
- G. Maintain daily documentation of all medication administered to the member or by self-administration.
- H. Report any unusual incidents to the member's team (Case Manager, Administrative Oversight Agency and guardian) and, when required, through the Reportable Events Reporting System.
- I. Report to the member's team all changes in household members or legal status of household members.
- J. Maintain current homeowner's or renter's insurance at all times.
- K. Provide the transportation to appointments and activities.
- L. Maintain a valid Maine driver's license and a properly registered, inspected, insured and maintained vehicle.
- M. Enter into a contract for professional support with the Administrative Oversight Agency.

The Department is seeking and anticipates receiving CMS approval for this Section. Pending approval, Covered Services will be provided as follows:

29.10 PROVIDER QUALIFICATIONS AND REQUIREMENTS (cont.)

29.10-5 Background Check Criteria-The provider must conduct background checks every two years on all employees, persons contracted or hired, consultants, volunteers, students, and other persons who may provide services under this Section. A background check is required for any adult who may be providing direct or indirect services where the member receives Shared Living. Background checks are required for any adult residing in a Shared Living Home. Background checks must be completed before a hire is finalized and prior to the employee working with members. Background checks on persons professionally licensed by the State of Maine will include a confirmation that the licensee is in good standing with the appropriate licensing board or entity. The provider shall not hire or retain in any capacity any person who may directly provide services to a member under this Section if that person has a record of:

- A. any criminal conviction that involves abuse, neglect or exploitation; or
- B. any criminal conviction in connection to intentional or knowing conduct that caused, threatened, solicited or created the substantial risk of bodily injury to another person;
- C. any criminal conviction resulting from a sexual act, contact, touching or solicitation in connection to any victim; or
- D. any other criminal conviction, classified as Class A, B or C or the equivalent of any of these, or any reckless conduct that caused, threatened, solicited or created the substantial risk of bodily injury to another person within the preceding two (2) years; or
- E. any criminal conviction within Title 29-A, chapter 23, subchapter 2, article 1, or Title 29-A, chapter 23, subchapter 5.

Employment of individuals with records of such convictions more than five (5) years ago is a matter within the provider's discretion after consideration of the individual's criminal record in relation to the nature of the position. The provider shall contact child and adult protective services (including OADS and the Office of Child and Family Services) units within State government to obtain any record of substantiated allegations of abuse, neglect or exploitation against an employment applicant before hiring the same. In the case of a child or adult protective services investigation substantiating abuse, neglect or exploitation by an employee of the provider, it is the provider's responsibility to decide what hiring action to take in response to that substantiation, while acting in accordance with licensing standards. Within 60 days of the effective date of this rule, all staff and all adults residing with a member must have all background checks completed. All background checks must be completed

The Department is seeking and anticipates receiving CMS approval for this Section. Pending approval, Covered Services will be provided as follows:

29.10 PROVIDER QUALIFICATIONS AND REQUIREMENTS (cont.)

every twenty-four (24) months thereafter. Costs for background checks are the responsibility of the provider.

29.10-6 Informed Consent Policy

Providers must put in place and implement an informed consent policy approved by the DHHS. For the purposes of this requirement, informed consent means consent obtained in writing from a person or the person's legally authorized representative for a specific treatment, intervention or service, following disclosure of information adequate to assist the person in making the consent. Such information may include the diagnosis, the nature and purpose of the procedure(s) or service(s) for which consent is sought, all material risks and consequences of the procedure(s) or service(s), an assessment of the likelihood that the procedure(s) or service(s) will accomplish the desired objective(s), any reasonably feasible alternatives for treatment, with the same supporting information as is required regarding the proposed procedure(s) or service(s), and the prognosis if no treatment is provided. At a minimum, a provider's informed consent policy must ensure that members served by the provider (and their guardians, where applicable) are informed of the risks and benefits of services and the right to refuse or change services or providers.

29.10-7 Reportable Events & Behavioral Treatment

Providers shall comply with all terms and conditions of the Department's Regulations Governing Reportable Events, Adult Protective Investigations and Substantiation Hearings regarding persons with Intellectual Disabilities or Autism as described in 14-197 CMR, chapter 12. All staff must receive training in mandatory reporting/ reportable events and Behavioral Regulations either before they begin work with members or, at the latest, six (6) months of being hired and every thirty six (36) months thereafter. All staff must receive the following Department sponsored training;

- A. Regulations Regarding Reportable Events, Adult Protective Investigations and Substantiation Hearings Regarding Persons with Mental Retardation and Autism. (14-197, Ch. 12)
- B. Regulations Governing Behavioral Support, Modification, and Management for People with Intellectual Disabilities or Autism in Maine (14-197, Ch. 5); and
- C. Rights and Basic Protections of a Person with an Intellectual Disability or Autism (Title 34-B §5605)

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29.10 PROVIDER QUALIFICATIONS AND REQUIREMENTS (cont.)

Completion of trainings should occur before staff begin work with members or within six (6) months of the date of hire and every thirty six (36) months thereafter. All staff, regardless of length of employment, must have documentation of training completion in their personnel file.

29.11 APPEALS

In accordance with Chapter I of the *MaineCare Benefits Manual*, members have the right to appeal in writing or verbally any decision made by DHHS to reduce, deny or terminate services provided under this benefit. The right to appeal does not extend to changes in law or policy adversely affecting some or all recipients. The appeal must be (a) requested in writing and mailed to the address below, or (b) requested by telephone by calling Local: 207-287-6598, Toll Free: 1-800-606-0215 or TTY:711.

Office of Aging and Disability Services
Department of Health and Human Services
11 State House Station
Augusta, ME 04333-0011

29.12 REIMBURSEMENT

Reimbursement methodology for covered services shall be the amount listed in Chapter III, Section 29, Allowances for Support Services for Adults with Intellectual Disabilities or Autism Spectrum Disorder or the provider's usual and customary charge, whichever is lower.

In accordance with Chapter I of the *MaineCare Benefits Manual*, it is the responsibility of the provider to seek payment from any other resources that are available for payment of the rendered service prior to billing MaineCare. Therefore, a service provider under this benefit is expected to seek payment from sources other than MaineCare that may be available to the member.

DHHS will conduct a review of provider records that may include, but is not limited to, staff schedules, payroll records and member records to substantiate service delivery and units of authorization.

29.13 BILLING INSTRUCTIONS

Providers must bill in accordance with DHHS billing instructions.

The Department is seeking and anticipates receiving CMS approval for this Section. Pending approval, Covered Services will be provided as follows:

29.14 APPENDIX I-Guidelines for Approval of Medical Add-On in Maine Rate Setting

The purpose of this Appendix is to detail guidelines for Office of Aging and Disability Services in approving a Medical Add-On to the established published rate. All current statutes, regulations, decree provisions, policies, and licensing standards regarding medical services are unaffected by these guidelines. This Appendix develops criteria that warrant an adjustment to the DHHS's established published rate for Community Support, Employment Specialist Services and Work Support Services.

The Clinical Review Team (CRT) is the entity within OADS that is responsible for review and approval, of all Medical Add-On rate increases for services under this section.

The rate is designed to support Members with intermittent or longer duration medical conditions. Changes or needs that may be considered for Medical Add-On include but are not limited to: support over and beyond routine services such as ventilators, nebulizers, diabetes management-insulin dependent, suctioning, seizure management-uncontrolled, chronic eating disorders, or persons with co-existing conditions that significantly affect physical movement and require near total physical assistance on a daily basis. Conditions related to surgeries, procedures, injuries and other short term conditions are also considered for the Medical Add-On rate increase.

The following standards and practices must be demonstrated in order for the CRT to approve a Medical Add-On:

A. Physician Order

1. There must be a written physician or physician's assistant's order, less than three (3) months old for the member. This order must specify:
 - a. The specific illness or condition to be addressed;
 - b. The specific procedure(s) that will be utilized;
 - c. The time span over which the treatment or intervention is expected to be needed. If the treatment or intervention is expected to be needed for an indefinite period of time then this expectation should be specified;
 - d. The anticipated frequency of treatment or intervention on a daily, weekly, or monthly basis;
 - e. Where applicable and possible:
 - i. The approximate length of time required for each episode of the treatment or intervention and

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The Department is seeking and anticipates receiving CMS approval for this Section. Pending approval, Covered Services will be provided as follows:

29.14 APPENDIX I-Guidelines for Approval of Medical Add-On in Maine Rate Setting (cont.)

- ii. The degree of licensure or certification required for those who carry out the treatment, and those who provide training and oversight relative to its application.

B. Planning Team

- 1. The team must meet or otherwise confer for the following purposes:
 - a. To review and complete the request for Medical Add-On and any additional documentation required for submission to the CRT.
 - b. To determine whether the setting where the member is served is appropriate to carry out the physician's recommended treatment or intervention; and
 - c. To determine how the member's needs shall be met and what the staffing requirements are.
- 2. All of these determinations and recommendations must be noted in the Personal Plan.

C. Provider Requirements

- 1. The provider must be an enrolled MaineCare provider.
- 2. For any physician or physician's assistant order specifying a skilled medical professional who shall train, monitor, or deliver treatment, the provider must have regular access to the professional, either as an employee, or via a contract, or via an established relationship; or alternatively, the provider must be able to gain this access in a time frame commensurate with the treatment requirements.

D. Approval Process

- 1. The CRT will review the information submitted with the request, the Personal Plan, information in the electronic record such as reportable events, crisis notes, as well as any applicable assessments or evaluations in the member's record.
- 2. The CRT will issue a written decision for the Medical Add-On, within twenty (20) working days of receipt of all required documentation. If additional information is required, a written request will be issued. Upon receipt of the additional information the CRT will approve or deny the request within ten (10) working days.

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29.14 APPENDIX I-Guidelines for Approval of Medical Add-On in Maine Rate Setting (cont.)

3. Approvals will include a specification of the duration of the Medical Add-On, as well as authorized daily or weekly units of service which require the Medical Add-On.
4. Treatments or interventions that are anticipated to be needed for an extended or indefinite period of time must be reviewed annually or more frequently as determined by the CRT. Verification of this continued need must be provided to the CRT within a year of the original approval, in order for the Medical Add-On to continue.

The Department is seeking and anticipates receiving CMS approval for this Section. Pending approval, Covered Services will be provided as follows:

29.15 APPENDIX II - “On Behalf Of” Covered Services

“On Behalf Of” Covered Services:

Support and supervision that is offered whenever the staff and the member are in the same physical environment is considered *direct support time*. This would include, for example, staff waiting for a member during a medical appointment or a home visit. Examples of acceptable services include:

Services and time that are directly related to a member: such as scheduling medical appointments, dental appointments and therapy appointments. This includes any time staff may need to spend discussing with a physician, dentist, or therapist any intervention regarding the member.

Services and time that are directly related to a member that are associated with that member’s personal plan, medical plan or behavioral plan including in-service training specific to a member’s personal plan, consultations with supervisors, therapist, clinicians, member’s employer and or medical staff; services relating to a member’s parent, guardian or Maine Developmental Services Oversight and Advisory Board (MDSOAB) representative; documentation, reports and presentations to review committees.

Services and time that are directly related to a member that are associated with home visits, family events and or family reunification including transporting a member to their parents, guardian, or friends home for visits, returning a member to their home, and any time spent during such a visit such as attending a family function with the member.

Services and time that are directly related to a member’s safety such as “shadowing” a member as he or she learns to take a bus.

“On Behalf Of” Non-Covered Services:

Services and time that are related to group services, or time that cannot be directly linked to member’s Personal Plan. For example, grocery shopping for a home.

Services and time that are related to home cleaning, home maintenance, facility cleaning or facility maintenance.

Services and time that are related to staff training, unless the training is specific and exclusive to the member.

Services and time that are related to landscaping, snow removal, spring clean-up or similar activities.

Services and time that are related to securing or maintaining a license or certificate such as a group home license, or CARF accreditation.

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Covered Services will be provided as follows:*

29.15 APPENDIX II - “On Behalf Of” Covered Services (cont.)

Services and time that are related to staff recruitment, even if the staff is being recruited for the member.

Services and time provided by a salaried staff member unless there is evidence that the salaried staff was working as a Direct Support Professional for the time being claimed.

The Department is seeking and anticipates receiving CMS approval for this Section. Pending approval, Covered Services will be provided as follows:

29.16 APPENDIX III Performance Measures

The primary goal of Performance Measurement is to use data to determine the level of success a service is achieving in improving the health and well-being of members. Performance Goals and Performance Measures assist to monitor quality, inform and guide reimbursement decisions and conditions of provider participation across MaineCare services. This focus on Performance Measurement is anticipated to enhance the overall quality of services provided and raise the level of public accountability for both the DHHS and MaineCare providers.

29.16-1 Performance Goals

Members receiving this service will experience improved or preserved functional abilities while being able to live in a safe and stable setting within the community.

29.16-2 Performance Measures

- a. 65% of members receiving Work Support-Individual services will have worked a total number of hours of paid employment during the quarter that is greater than the total number of Work Support-Individual support hours they received during the quarter.
- b. 100% of members receiving Work Support Services-Group making less than minimum wage, will have a Personal Plan in place that identifies how Work Supports is being utilized to increase the member's productivity and ensure good job match in order to move toward an hourly wage that meets or exceeds the State of Maine minimum wage standard.

29.16-3 Performance Measure Data Source

Providers must electronically enter member level data into a DHHS defined web-based data collection system by the fifteenth of the month after the quarter ends.

29.16-4 Performance Measurement Compliance

DHHS may exercise the following steps to ensure compliance:

Step 1: DHHS will notify the provider in writing of any compliance and performance issues identified by DHHS staff. The notice will include the performance provision that is in noncompliance and a date by which the provider will correct or remedy the identified non-compliance/performance issue.

Step 2: If the compliance/performance issues described by DHHS in Step 1 have not been addressed by the specified dates, the provider and a representative of DHHS will

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29.16 APPENDIX III Performance Measures (cont.)

meet, discuss, and document the compliance/performance issues. DHHS and the provider will develop a corrective action plan which must include:

1. A statement of the corrective actions required for compliance with the Performance Measures;
2. The date by which the provider will comply with the terms of the Performance Measures;
3. The consequences for non-compliance which may include the sanctions described in Chapter I of this manual or other consequences as determined by the DHHS; and
4. Signatures of the provider and DHHS representative.

Step 3: In accordance with Chapter I, if the provider fails to undertake the corrective actions in the corrective action plan, DHHS may impose sanctions, up to and including termination of the Provider Agreement in accordance with the procedures described in Chapter I, *General Administrative Policies and Procedures*, Section 1.03-4, “Termination of Participation by Provider or DHHS” and Section 1.19, “Sanctions/Recoupments”.

The Department is seeking and anticipates receiving CMS approval for this Section. Pending approval, Covered Services will be provided as follows:

29.17 APPENDIX IV- Additional Requirements for Section 29 Providers of Community Support Services, Employment Specialist Services, and Shared Living

Providers must first be approved by OADS and subsequently enroll in MaineCare in order to provide services and be reimbursed under this Benefit.

Prior to approval and thereafter, the provider, any contractor or subcontractor of the provider, or other individuals compensated by the provider for assisting in the care of member(s) shall be subject to site visits and interviews to ensure compliance with federal and state laws and regulations and the operational, health, safety and environmental requirements set forth herein. The provider shall permit OADS representative(s) to visit the member and the member's home and program as often as DHHS deems necessary to assure quality services, including unscheduled visits.

The provider must submit the following to the OADS District Resource Coordinator:

- A. Application Form. Initial applications shall be submitted using DHHS forms to the OADS District Resource Coordinator. The initial application shall be signed and dated by the provider owner and the presiding officer of the Governing Body, if applicable.
- B. The initial application shall be accompanied by documents described in this section of rule demonstrating compliance with requirements described in the following portions of these rules:

1. Organizational Structure

a. Ownership

- i. **Authority.** The provider shall maintain documented evidence of its source(s) of authority to provide services. Such evidence will include articles of incorporation, corporate charter, or similar documents.
- ii. **Records.** Corporations, partnerships, or associations shall maintain records of the contact information for officers, directors, charters, partnership agreements, constitutions, articles of association and/or by-laws, as applicable.

b. Capacity

- i. **Professional Qualifications.** Provider shall have written job descriptions for all positions within the agency. The provider shall acquire and retain evidence to demonstrate that all persons engaged in the provision of services regulated by the State of Maine, other applicable government entities, professional associations or similar bodies are appropriately qualified, certified, and/or licensed.

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29.17 APPENDIX IV- Additional Requirements for Section 29 Providers of Community Support Services, Employment Specialist Services, and Shared Living (cont.)

1. The management shall have related experience demonstrating competency and experience in the health or human service setting and remain in good standing of licensure or certification
2. Supervisors of Services, Employment Specialist Services, or Community Support Services shall be required to meet all of the requirements of the DSP position.
3. **Copies of contracts.** When the provider manages services delivered by another provider, a documented cooperative, affiliated service, or subcontracting agreement shall exist. This agreement shall be updated and renewed at least annually. The provider shall ensure that services provided through an affiliation agreement or subcontract complies with these rules and any contractual requirements.

c. Organization Chart

- i. The provider will outline the business structure in an organizational chart, identify management, staff and other individuals compensated by the provider for assisting in the care of member(s) and illustrating the supervisory responsibilities; include credentials as required for the service delivery.

2. Personnel Management

- a. **General Orientation Program.** The provider shall have a written orientation program that is relevant to the organization as a whole and provided to all new employees, interns, and volunteers. This orientation shall include, but not be limited to:
 - i. an overview of the service delivery system as a whole, including the availability of peer and family supports and other elements of services;
 - ii. the provider's mission, philosophy, clinical services, and therapeutic modalities, policies, and procedures
 - iii. member's right to privacy and confidentiality
 - iv. safety and emergency procedures general to the provider;
- b. **Position Specific Orientation and Training.** The provider shall have personnel policies that includes a description of the education, experience, and training required for Direct Support Professionals, Supervisors, and Program Directors.

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29.17 APPENDIX IV- Additional Requirements for Section 29 Providers of Community Support Services, Employment Specialist Services, and Shared Living (cont.)

The policy shall address any provider requirement for a valid driver's license, personal insurance limitations, computer proficiency, and any specific training specified by the provider and include a component specific to monitoring continued compliance.

The policy should note any requirement that the DSP will receive additional training specific to member(s) needs as addressed in the Personal Plan.

- i. The provider shall provide to all employees, interns, and volunteers, orientation specific to the duties and responsibility for which they were retained or accepted, and ensure the appropriate certification and training requirements specified in this rule and applicable governing regulations which includes but is not limited to the following:
 1. Person Centered Planning Process as outlined in 42 CFR §441.303
 2. Medication Administration Training required for all DSPs who assist members with over-the-counter and prescribed medication
 3. Cultural competence training relevant to the populations served, including: age, gender, race, religion, culture, and sexual orientation.

3. Operational Policies and Procedures

- a. **General Policies.** The provider shall maintain policies governing essential elements of service provision. Policies include and are not limited to:
 - i. **Behavioral Regulations.** The provider shall comply and ensure that all staff and other individuals compensated for assisting in the care of member(s) comply with the DHHS' Regulations Governing Behavioral Support, Modification and Management for People with Intellectual Disabilities or Autism in Maine, (14-197 CMR Ch. 5.)
 - ii. **Rights and Protection.** The provider shall comply and ensure that all staff and other individuals compensated for assisting in the care of member(s) comply with 34-B MRSA §5605, Rights and Basic Protections of a Person with an Intellectual Disability or Autism.
 - iii. **Reports of Abuse, Neglect or Exploitation.** The provider shall maintain a specific policy and procedure governing the reporting, recording, and review of allegations of abuse, neglect, or exploitation of persons receiving services, in accordance with

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29.17 APPENDIX IV- Additional Requirements for Section 29 Providers of Community Support Services, Employment Specialist Services, and Shared Living (cont.)

applicable laws, rules, and regulations, including but not necessarily limited to the Adult Protective Statute. The provider shall comply and shall ensure that all staff and other individuals compensated by the provider for assisting in the care of member(s) comply with DHHS' Regulations Regarding Reportable Events, Adult Protective Investigations and Substantiation Hearings Regarding Persons with Mental Retardation and Autism (14-197 CMR Ch. 12, Regulations Regarding Reportable Events, Adult Protective Investigations and Substantiation Hearings Regarding Persons with Intellectual Disabilities or Autism), and state law on reportable events and reports of abuse, neglect, and exploitation (22 MRSA §3477, Persons Mandated to Report Suspected Abuse, Neglect or Exploitation; 34-B MRSA §5604-A, Duty to Report Incidents; Adult Protective Services Act and Rights Violations; and 22 MRSA §3740, *et seq.*, *Adult Protective Services Act*).

- iv. The provider shall maintain written policies and procedures and have reporting forms available at each site where members are served to ensure compliance with the above mentioned laws and regulations governing Reportable Events, Rights and Basic Protections and Reporting of Abuse, Neglect and Exploitation.
 - v. **Duration of Care.** The provider shall maintain policies that outline the admission process, discharge procedures for planned or unplanned termination of services, the referral of individuals deemed inappropriate or not qualified for a particular program to other programs to meet the individual's needs, and the mechanisms undertaken to eliminate wait lists or the justification for having no wait list.
 - vi. **Medication Management.** The provider shall maintain specific policies and procedures ensuring that any staff and other individuals compensated for assisting in the care of member(s) receive appropriate training in and comply with medication administration protocol that is in accordance with DHHS expectations.
4. **Quality Management.** The provider shall have written policies governing the development and maintenance of an effective quality management program to ensure quality service delivery consistent with federal and state laws and regulations. The program shall:
- a. identify areas determined by the provider to be critical to quality service provision.
 - b. describe goals set by the provider to improve services or service delivery and shall describe indicators to measure achievement of the goals.
 - c. include on-going, year-round, regular activities to measure goal achievement.

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29.17 APPENDIX IV- Additional Requirements for Section 29 Providers of Community Support Services, Employment Specialist Services, and Shared Living (cont.)

- d. include a component describing the system to monitor compliance with federal and state laws and regulations.
 - i. **Evaluation.** The findings of the quality management process shall be reviewed at least annually by the provider.
 - ii. **Plan of Correction.** A finding of deficiency in violation of federal or state laws or regulations shall be reported to DHHS within a 30-day period and be accompanied by a Plan of Correction to be deemed acceptable by the DHHS.

5. Financial Management

- a. The provider shall make available to DHHS upon request, a federal income tax return for the year in question, a statement of finances including income statement, balance sheet, cash flow statement, operations and program budget, and profit projection.

6. Environment

- a. **Fire and Safety Inspections.** Upon receipt of the completed application, fire and safety inspections may be conducted by authorized representatives of organized fire departments, by the State Fire Marshall's office and code enforcement officers.
 - i. Fire drills shall be conducted and documented at least four times per year
 - ii. Emergency Management Plan shall address the event of loss of essential services such as electricity, water, and heat
- b. **Structures.** The provider shall meet current requirements of the *Americans with Disabilities Act of 1990*, the *Rehabilitation Act of 1973*, and the *Maine Human Rights Act*. New construction, renovation, remodeling or repair shall be in full compliance with the *Americans with Disabilities Act of 1990*, the *Rehabilitation Act of 1973*, and the *Maine Human Rights Act*. All structures used in the delivery of waiver services shall be maintained in good repair, free from danger to the member's health or safety, and shall be appropriate to the services provided. The provider shall ensure that:
 - i. furnishings and equipment are appropriate to the member's age and physical conditions,
 - ii. rooms and areas are clean, appropriately lit, and adequately heated and ventilated based on the needs of the members,

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29.17 APPENDIX IV- Additional Requirements for Section 29 Providers of Community Support Services, Employment Specialist Services, and Shared Living (cont.)

- iii. the square footage of rooms (i.e. bathrooms, bedroom, dining areas) are appropriate and adequate for the level of privacy, purpose of the space and to accommodate users ,
 - iv. utilities are maintained in good repair and in a manner consistent with applicable codes,
 - v. a storage area that shall provide secure space used for the proper storage of potentially harmful materials (i.e. chemicals, medications, and firearms).
- c. **Integrated Settings.** The setting in which residential. community supports, and employment specialist services are provided shall be integrated in and support full access to the greater community to the fullest extent and
- i. be one of choice and based on the needs of the individual as indicated in the member's Personal Plan;
 - ii. ensure a member's rights of privacy, dignity and respect and freedom from coercion and restraint;
 - iii. support opportunities to seek employment in competitive integrated settings, engage in community life, control personal resources, optimize autonomy and choice in activities and schedules, facilitate choice of services and providers, and access to services in the community;
 - iv. The providers may modify programs as needed to comply with HCB settings requirements above or assist individuals to relocate to compliant settings of choice.

In the event that any provider fails to meet the requirements set forth in this Appendix, DHHS will notify the provider in writing of any remedies needed to bring the provider into full compliance. DHHS also will issue a plan of correction setting forth the timeframes within which the provider's compliance must be achieved. Failure to comply with the plan of correction within the stated timeframes may result in the provider's disenrollment for services and/or any other sanctions penalties allowed under the *MaineCare Benefits Manual* or other state or federal law.